The Governor's Plan for a Healthier Indiana

- **Protection: Protect Hoosier children from smoking and disease**
- **Prevention: Encourage Hoosiers to seek preventive care**
- **Peace of Mind: Provide health coverage to thousands of uninsured Hoosiers**
- **Personal Responsibility: Give individuals control of their health care decisions**

Governor Mitch Daniels proposes to direct the proceeds from an increased cigarette tax to improve the health of Hoosiers. The Governor's plan includes funding for smoking reduction programs and childhood immunizations. In addition, the plan will provide health insurance to uninsured Hoosiers least able to afford coverage. This innovative plan promotes personal responsibility for health and lays a foundation for greater transparency in health care costs and financing. The Governor's Plan will reduce the number of uninsured in Indiana, thus slowing the trajectory of health care premiums created by cost shifting from uninsured to insured patients. Moving away from traditional subsidies to hospitals, this plan entrusts Hoosiers with the power to be value-conscious consumers of health care.

Smoking Reduction

- Raising the cigarette tax lowers youth and adult smoking
- Cigarette tax proceeds will help support local programs that help Hoosiers to stop smoking and prevent tobacco use

Immunizations

- Provide funding to ensure that all Hoosier children have access to immunization to prevent diseases such as hepatitis B, polio, mumps, measles, and whooping cough

Personal Wellness Responsibility (POWER) Accounts: Trusting Hoosiers to Make Value-Based Decisions

- The Plan provides:
  - A POWER Account valued at $1,100 per adult to pay for medical costs. Contributions to the account are made by the State and each participant (based on ability to pay). No participant will pay more than 5% of his/her gross family income on the plan.
  - A basic commercial benefits package once annual medical costs exceed $1,100.
  - Coverage for preventive services up to $500 a year at no cost to participants.

- At the end of the year, individuals can withdraw a portion of unspent funds, as long as a minimum balance is maintained and age and gender-appropriate preventive services have been completed.

- POWER accounts give participants a financial incentive to adopt healthy behaviors that keep them out of the doctor's office. When they do seek health care, plan participants will seek price transparency so they can make value conscious decisions.

Financing: Assuring Fiscal Responsibility to Indiana's Taxpayers

- The Governor's Plan will be financed through revenues from an increase in Indiana's cigarette tax, participant contributions to the POWER Accounts, and federal funds available to support low-income health care.
- Since hospitals will treat fewer uninsured patients, The Governor's Plan proposes to redeploy some of the federal dollars currently provided to hospitals that serve low-income populations (known as "Disproportionate Share" or DSH payments).
- The number of Hoosiers that can be provided coverage under The Governor's Plan depends on the amount of revenue raised. (A 25-cent cigarette tax increase would provide coverage for approximately 120,000 Hoosiers; a 50-cent increase would cover 200,000 people).

THE GOVERNOR'S PLAN FOR A HEALTHIER INDIANA
UNINSURED FACT SHEET

The Problem:

- On any given day, there are approximately 561,000 Hoosiers without health insurance. Indiana has experienced a steady increase in the number of uninsured since 2000, a rate of growth that exceeds national average.
    - Of this group, approximately 62% are working-age adults with incomes at or below 200% of the Federal Poverty Level (e.g., $40,000 for a family of four). Medicare and Medicaid generally provide coverage for children, the elderly, disabled adults and pregnant women.
- Many Hoosier businesses, especially small companies, have dropped coverage and no longer provide health insurance to their employees.
    - From 1999 to 2004, Indiana had the nation's second highest percentage decline in workers receiving employer-sponsored health insurance.
- Hospitals and other health care providers shift "uncompensated care" costs (costs of providing care for uninsured individuals) back to insured patients and their insurance companies by charging these customers more for services.
    - These shifted costs have a significant impact on Hoosiers. Each Indiana family with health insurance paid an additional $953 in premiums in 2005 to cover the cost of the uninsured. By 2010, premiums are expected to be $1,494 higher for families to account for the cost of the uninsured.
- Many Hoosiers face bankruptcy because they are unable to pay their medical bills. As a result, Indiana has the highest per capita rate of medical bankruptcies in the nation, affecting more than 77,000 Hoosiers.
- Current government programs to address the uninsured have provided subsidies to hospitals to offset their uncompensated care costs. These programs entitle institutions, but do not incentivise providers to offer quality services and leave the uninsured without a choice of where and how to receive their health care.
- Other programs that directly target the uninsured have unlimited benefits (such as paying for taxi services) and thus, provide no incentive for participants to take responsibility for their health or to utilize health care services as efficiently as possible.
- Hoosiers fall short when it comes to getting their requisite preventive care. They also face many health challenges, which make us an expensive population to insure.
    - Women in Indiana receive both mammograms and pap smears at lower rates than the national average.
    - 66% of Hoosier men age 50 and older did not have a colonoscopy in the last 5 years. This is six percent more than the national average.
    - Indiana ranks 2nd nationally in the percentage of adults who are smokers; over 27% of Hoosier adults are smokers, which is 6.6% higher than the national average.
    - Almost 60% of Hoosier adults are obese, and Indiana ranks 10th nationally in percentage of adults who are overweight/obese.
- The high cost of health care limits Indiana's economic development efforts as many companies find the price of doing business here too great. This restricts the economic growth of current Hoosier businesses and discourages prevent new businesses from coming to Indiana.

The Governor's Plan for a Healthier Indiana

TOBACCO USE

The Problem – Adults

- In 2005, 27% of adults in Indiana smoked, a significant increase from 2004 (24%)
- Indiana ranks 2nd among all states in adult smokers (7th in 2004)
- Indiana's adult smoking rates are considerably higher than the U.S. rate of 20%

The Problem –Youth

- 10,200 Hoosier children under 18 start smoking each year and 160,000 kids under the age of 18 will die prematurely from smoking.
- Smoking rates increase as children get older:
    - 5% of 6th graders smoke
    - 10% of 8th graders smoke
    - 19% of 9th graders smoke
    - 26% of 12th graders smoke

The Problem – Indiana Economy

- Medical costs related to smoking in Indiana amount to more than $1 billion annually
- Annual Indiana Medicaid expenditures related to tobacco are more than $400 million
- For every pack of cigarettes sold in Indiana, Hoosiers spend $7.10 in health care costs related to smoking

The Problem – Indiana Lacks Adequate Funding For Tobacco Prevention & Cessation

- Federal guidelines recommend Indiana invest $34 million toward tobacco prevention and cessation programs; today, Indiana invests $10.8M
- While smoking rates have fallen nationally to an all-time low of 20%, Indiana's rates have essentially remained the same or risen over the last 10 years
- Indiana has a low cigarette tax national ranking of 36th

IMMUNIZATION GAP

The Problem

- 22% of Indiana's children do not receive the requisite immunizations by their 2nd birthdays and are not completely immunized against preventable diseases like hepatitis B, polio, mumps, measles, and whooping cough
- Indiana ranks 39th in the nation in immunizations for two-year-olds
- Nearly $25 in health care costs can be saved for every $1 spent on childhood immunizations

Sources: IETCP, ISDH, and Indiana University

THE GOVERNOR'S PLAN FOR a HEALTHIER INDIANA

FREQUENTLY ASKED QUESTIONS (FAQs)

Eligibility

Who is eligible for The Governor's Plan?

The Governor's Plan will provide health insurance for uninsured Hoosiers who earn less than 200% of the federal poverty level (FPL) and who are without access to employer-sponsored health insurance. For example, the plan will cover:

- Parents who earn between $9,800 and $40,000 per year (22%-200% of FPL)
- Adults without children between the ages of 18-64 who earn between $9,800 and $19,600 (100%-200% of FPL)

How many people will be eligible for The Governor's Plan?

We estimate that over 350,000 Hoosiers are potentially eligible. However, the number of participants will depend on available funding.

How is this plan different from a traditional entitlement program?

The Governor's Plan is not an entitlement. The number of people who can enroll in the plan is entirely dependent on available funding. Eligibility will be on a first-come, first-served basis.

The Governor's Plan requires each participant to make a modest financial contribution, and it provides incentives for participants to stay healthy, be value- and cost-conscious, and to utilize services in a cost-efficient manner. This plan covers essential health services and is similar to commercial plans. In contrast, Medicaid has unlimited benefits and services, and recipients have no incentive to be responsible for their health status, to be mindful of costs, or to utilize health care services efficiently.

What if you are income eligible but you already have insurance? Can you drop your existing insurance and join The Governor's Plan?

No. The Governor's Plan is only open to Hoosiers who have been uninsured for a minimum of six months. The six-month requirement is intended to prevent employers from canceling their coverage, and to prevent employees who have employer-sponsored coverage from taking a place in The Governor's Plan that would otherwise go to an uninsured person.

What if your employer offers health insurance, but you have chosen not to participate?

If a person has access to employer-sponsored health insurance, he or she is not eligible for The Governor's Plan.

Are there any residency requirements?

Plan participants must be U.S citizens. Additionally, although the current Indiana Medicaid program does not enforce any time-related residency requirements, The Governor's Plan will require an individual to be a resident of Indiana for at least six months.

Plan Benefits

Are there any services that are not covered?

The Governor's Plan does not cover outpatient mental health services because eligible Hoosiers already receive these services from the existing Hoosier Assurance Program. Dental and vision services are not covered.

Are brand name prescriptions covered?

The POWER Account may be used to pay for generic drugs or the lowest priced brand product if no generic is available. Once the account is depleted, the insurance plan will offer the same coverage. Participants may elect to purchase more expensive brand name drugs, but will be responsible for paying the difference in cost from their own funds.

Does The Governor's Plan discourage Hoosiers from using their plan for critical health care services such as preventive care? How will Hoosiers be healthier under The Governor's Plan?

The Governor's Plan includes free preventive health services for up to $500 a year. Services such as annual physicals, mammograms, colorectal screenings, and smoking patches will help Hoosiers avoid many costly services in the future by catching health problems earlier and encouraging them to adopt healthier lifestyles.

The Governor's Plan Contribution Requirements

How much will participants contribute financially? What if you are already paying premiums for your children to participate in Medicaid?

Monthly required contributions are affordable and will range from $42 for a single adult earning $9,800 to $167 for a family of four with two adults and two children. **Participants will contribute no more than 5% of their gross family income to have the security of health insurance.** The exact amount of the contribution will depend on income and family size, and will be prorated to account for any existing contributions to Medicaid.

How will the contribution be collected?

Most contributions will be collected through employer payroll deduction. There will also be alternative mechanisms for participants to submit payments directly to the State.

POWER Accounts

What is a Personal Wellness Responsibility (POWER) Account, and how will participants pay for the first $1,100 in health care services?

Modeled in the spirit of a traditional Health Savings Account (HSA), all participants will have a POWER Account established in their name, in addition to a health plan that will cover health care expenses above the POWER Account. The account will contain the monthly contributions made by participants in addition to a State contribution for a combined total of $1,100 per adult. Participants can use this to pay for their initial medical expenses.

How much does the State contribute to the account?

The State's contribution will vary according to a sliding scale based on a participant's financial ability to contribute to the account. The State will subsidize the account to ensure there is a total of $1,100 per adult in the account. For example, if a participant's contribution is $600, the State will contribute $500.

Does the State make its contribution on a monthly basis as well?

No. The State will make its entire contribution at the time of enrollment, to ensure there is money in the account when the plan begins.

Are there any restrictions on how the funds can be used?

The POWER Account may be used to pay for any service covered by The Governor's Plan.

What happens if a participant incurs medical costs before the POWER Account is fully funded?

Similar to common practice today, the participant will be encouraged to work out a payment plan with their providers for the balance between the State's contribution and $1,100 out-of-pocket expenses the plan requires.

How can a plan participant access funds in their POWER Account?

Participants will access the account with a debit card to pay eligible medical expenses, up to the account limit of $1,100 per adult.

What happens if there is money left in the account at the end of the year?

At the end of 12 months, individuals can access all funds over $500, but only if they have completed preventive services deemed appropriate for their specific age, gender, and preexisting conditions.

What happens to funds in the account at or below $500 for persons who remain eligible for The Governor's Plan?

The next year's State and participant contributions are pro-rated to reflect the balance in the account.

What happens to the balance of the account if a person is no longer eligible for The Governor's Plan?

Participants get back their share of what remains in the account. (Ex: If there is $300 left in the account, and the participant contributed a third of the account overall, then he/she would receive $100).

Administration

Who will administer The Governor's Plan? Will this be another FSSA program?

Commercial insurance carriers will offer the plan. FSSA and the Department of Insurance will oversee the contracts with these carriers.

Will all Indiana carriers offer the plan?

All carriers will be invited to respond to our request for proposals. However, there will be a limit on the number of plans offered to participants.

Will there be any variation between the plans?

Insurance companies will provide a commercial benefit plan to participants. Plans will compete on the basis of the provider networks they offer, as well as customer service options they make available to participants. This free market competition is intended to help assure the high quality of plan services.

What is the role of the federal government in the Governor's Plan?

The plan financing requires a significant contribution from the federal government, and therefore, will require federal approval.

Will providers be paid at traditional Medicaid rates?

No. Providers will be paid at Medicare rates, which are approximately 30%-40% above Medicaid rates, but are still below commercial provider rates. The Governor's Plan wants to assure there is an adequate delivery system to serve the newly insured, as well as an environment that promotes quality through competition among providers.

Employers

Can employers make a contribution to their employee's POWER Account?

Yes. Employers may elect to make contributions to the POWER Account to offset their employee's required contributions.

What keeps employers from dropping current coverage so that their employees can join the Governor's Plan?

Employers would have to drop their coverage for six months for their employees to become eligible for The Governor's Plan. Because of the income criteria, not all employees may qualify, leaving those at higher incomes without coverage. Thus, employers should not be any more tempted to drop employee health care coverage than they are currently.

How will The Governor's Plan help lower the rate of health insurance premium growth for Hoosier businesses?

The Governor's Plan will significantly reduce the number of uninsured Hoosiers. With more insured Hoosiers, there is less cost-shifting to insured populations, potentially lowering the rates of premium growth.

How does The Governor's Plan encourage personal responsibility and cost-conscious decision-making?

Participants have the opportunity to recover their contributions to the plan through the form of a "cash back" option and/or reduced contributions in future years.

How will the plan encourage price transparency for all Hoosiers?

Since participants will have an incentive to obtain the best possible pricing, they will seek information regarding the cost of the services they receive. Providers will be encouraged to make their pricing and quality information more accessible to all Hoosiers so consumers can make informed decisions about the services they purchase. As cost-shifting is reduced, providers (and insurance carriers) will not have to inflate their costs and the information they provide will be more accurate.

When does the program begin?

The plan requires approval from the federal government as well as the Indiana General Assembly, but could start as early as 2008.

The Governor's Plan for a Healthier Indiana:
POWER Account Contributions

Example 1: Single Adult
$1,100 POWER Account

% of Federal Poverty Level	100%	150%	200%
Annual Income	$9,800	$14,700	$19,600
Participant Contribution	$490	$735	$980
Total Monthly Contribution	$41	$61	$82
Total State & Federal Contribution	$610	$365	$120

Example 2: Family of 3 (1 adult & 2 kids)
$1,100 POWER Account

% of Federal Poverty Level	100%	150%	200%
Annual Income	$16,600	$24,900	$33,200
Annual Premium Contribution for 2 kids in Medicaid	$0	$396	$600
Participant Contribution	$830	$849	$1,060
Total Annual Contribution= 5% of Annual Income	$830	$1,245	$1,660
Total Monthly Contribution	$69	$104	$138
Total State & Federal Contribution	$270	$251	$40

Example 3: Family of 4 (2 adults & 2 children)
$2,200 POWER Account

% of Federal Poverty Level	100%	150%	200%
Annual Income	$20,000	$30,000	$40,000
Annual Premium Contribution for 2 kids in Medicaid	$0	$396	$600
Participant Contribution	$1,000	$1,104	$1,400
Total Annual Contribution= 5% of Annual Income	$1,000	$1,500	$2,000
Total Monthly Contribution	$83	$125	$167
Total State & Federal Contribution	$1,200	$1,096	$800

2006 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$ 9,800	$12,250	$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

SOURCE: *Federal Register*, Vol. 71, No. 15, January 24, 2006

The Governor's Plan: Benefits Package

- Lifetime Maximum $1 Million
- Annual Maximum $300,000
- $1,100 Deductible

Benefit	Covered	Not Covered	Comments
Prescription Drugs	•		Coverage up to cost of generic equivalent (if available)
Preventive Care	•		$500 annual first dollar coverage
Emergency Room	•		$50 co-pay when there is no inpatient admittance
Physician Office Services	•		
Inpatient Hospital	•		
Outpatient Services	•		
Diagnostic Services (lab and X-ray)	•		
Urgent Care Center	•		
Outpatient Therapy Services	•		
Home Health Services	•		
Human Organ and Tissue Transplant	•		
Medical Supplies and Durable Medicaid Equipment	•		
Maternity		• Provided by Medicaid	
Mental Health Services		• Provided by Medicaid through HAP program	
Vision		•	
Dental		•	
Disease Management	•		Health Coaches and assistance to those with chronic disease.

Out of pocket limit is 5% of annual income stated in letter to State Officials from Centers for Medicare and Medicaid Services (CMS). June 2006.

The Governor's Plan: Preventive Care Services

Preventive Care Services	Male 19-35	Female 19-35	Male 35-50	Female 35-50	Male 50-64	Female 50-64
Colonoscopy					•	•
Annual physical	•	•	•	•	•	•
Flu shot					•	•
Pap smear		•		•		•
Cholesterol testing			•	45+	•	•
Mammogram		•		•		•
Chlamydia screening		Under 25				
Blood glucose screening	•	•	•	•	•	•
Tetanus-diphtheria booster	•	•	•	•	•	•